

**Toward Contraceptive Self-Reliance in Turkey:
Results from a Pilot Test of a Cost-Sharing Mechanism**

Full Report

by

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May 2001

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Acknowledgments

Access to family planning services is one important factor contributing to quality of life in Turkey. Public sector reliance on foreign donor support for family planning is nearly ended and new ways of generating resources are required. The pilot study on testing a donation policy for achieving contraceptive self-reliance in Turkey (also referred to as a targeting strategy) was conducted jointly by the Turkish Ministry of Health, General Directorate of Mother and Child Health and Family Planning, and the POLICY Project with funding by U.S. Agency for International Development (USAID). POLICY is a five-year project funded by USAID under Contract No. HRN-C-00-00-00006-00, beginning July 7, 2000.

Appointed staff from the organizations mentioned below have successfully undertaken all the activities necessary for the completion of the pilot study:

- Ministry of Health (GD MCH/FP)
- Adana Provincial Health Department (MCH/FP Division)
- Icel Provincial Health Department (MCH/FP Division)
- Izmir Provincial Health Department (MCH/FP Division)
- Health and Social Aid Foundation

The authors of this report wish to express their gratitude to all the health personnel who not only recognized the value of the study, but who also contributed so generously of their time and performance in implementing the study. Provincial-level health personnel function at the very heart of the family planning service system as was demonstrated by the successful completion of this study.

Abbreviations

BRF	Branch Reporting Form
CTF	Client Tracking Forms
FRF	Facility Reporting Forms
HSAF	Health and Social Aid Foundation
IEC	Information, education, and communication
IUD	Intrauterine device
MOH	Ministry of Health
NGO	Nongovernmental organization
OC	Oral contraceptives
PHC	Primary health care
SSK	Social Insurance Organization
TL	Turkish Lira
TOT	Training of trainers
USAID	United States Agency for International Development

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I. Introduction

Since 1995, the government of Turkey has been engaged in defining and implementing strategies to become self-reliant in its public sector family planning program. Turkey's family planning program had historically been reliant on donors for contraceptive supplies. By 2000, however, donors ceased providing these supplies. In response, the government of Turkey defined two principal features of a national self-reliance strategy. The first feature consists of annual allocations from the public sector budget; the government has successfully mobilized about 60 percent of the resources needed to purchase contraceptives for the public sector program. The second feature of the national strategy, and the topic of this report, is a donation policy, whereby clients are asked to contribute a share of the commodity cost at public health care facilities.

The donation policy is designed to target subsidies for contraceptive supplies to the poor. Clients seeking contraceptives from public sector outlets are asked to make a voluntary donation for the supplies. Clients who declare that they are unable or unwilling to make a donation are presumed poor and exempted from donating; supplies are then provided to them free.

The donation policy is to be implemented at primary health care (PHC) facilities operated by the Ministry of Health (MOH), mediated by the Health and Social Aid Foundation (HSAF), in whose name donations are to be collected. The policy brings family planning services into line with other health services, for which a donation policy has been in place for several years. The HSAF will manage the collected monies, centralized at HSAF headquarters for the procurement of contraceptives, which will then be channeled back to the MOH to augment supplies purchased with MOH funds.

A preliminary feasibility study, conducted in 1998, concluded that the HSAF is a viable mechanism for raising and using resources for contraceptive purchases and that family planning clients are willing to pay for supplies. It also determined that a donation policy could generate sufficient revenue to close the gap between available public budgeted resources and the total amount required for contraceptive purchases.¹ A pilot study was subsequently conducted to test

¹POLICY Project. 1999. *Turkey's Health and Social Assistance Foundation: Feasibility Study of its Role in Raising Resources for Contraceptive Commodity Procurement*. Washington, D.C.

various operational features of a donation policy. This report includes findings from a pilot study that

- Assessed the attitudes and behavior of public sector family planning clients when asked to make a donation for contraceptives received at MOH facilities. Specifically, it assessed how the donation policy affected demand for family planning services at MOH facilities
- Assessed the attitude of MOH providers and administrators toward the targeting plan and their level of compliance with the elements of the plan.
- Tested the mechanism designed for the targeting plan.
- Collected data for use in estimating national revenue potential and determining optimum donation levels.

II. Design

A. Locations, Implementation Period, and Donation Prices

The HSAF is at the core of the donation policy. The HSAF is a nongovernmental organization (NGO) that operates parallel to most MOH facilities, collecting donations from clients for most health care services. Before the pilot study, donations for family planning services were requested only for IUD insertions; all other family planning services, including contraceptive supplies, were free. During the pilot study, the HSAF began collecting donations for oral contraceptives (OCs), condoms, and IUDs dispensed to family planning clients (other family planning services will remain exempt from the donation policy) and managing the revenue.

The pilot study was conducted from June 5 to December 5, 2000, in four areas: three intervention areas and one control area. Three donation levels—high, medium, and low—were determined, with one of the levels applied to each of the three intervention areas. The intervention areas selected were Mersin District in Icel Province (high donation), Tarsus District in Icel Province (medium donation), and Seyhan and Yuregir Districts in Adana Province (low donation). Izmir Province served as the control area. The intervention areas were selected in part because their geographic separateness minimized the possibility that clients would cross over to the other areas to take advantage of donation-level differences. All family planning clients of MOH PHC facilities in each intervention area were subjected to the donation policy; however, no donations were collected in the control area.

Several MOH PHC facilities do not collect donations under the HSAF banner. Most of these facilities are large and operate their own stand alone associations that generate funds from client donations, retaining 100 percent of collected revenue for their own use. All such PHC facilities in the three pilot intervention areas were asked to participate in the family planning donation policy. Although all agreed to participate, for these facilities participation represented a greater adjustment to collecting donations and using revenues than for HSAF-affiliated facilities.

Table 1 shows the donation amounts for contraceptive supplies obtained at PHC facilities that were applied in each of the three intervention areas. The donation amount for an IUD increased,

adding the cost of the device to the preexisting insertion service donation amount. Donation charges for oral contraceptives (OCs) and condoms at PHC facilities were entirely new.

Table 1
Donation Levels in the Three Intervention Areas,
Compared to Average Private Market Prices (US\$ equivalents)

	Client Donations in the Pilot Study			Private Market Prices	
	High donation area	Medium donation area	Low donation area	Average	Range
IUD	4.51	3.38	2.26	14.50	4.60–29.00
OCs (2 cycles)	2.26	1.50	1.13	6.00	3.29–8.60
OCs (1 cycle)	1.13	0.75	0.38	3.00	1.65–4.30
Condoms (12 pieces)	1.13	0.75	0.38	6.67	2.69–10.77

Donation levels for each commodity were established first for the high donation area. The donation level was computed to recover the MOH's estimated unit cost for each commodity, and then increased by 28 percent to recover the agreed-on facility and HSAF provincial branch donation revenue retention levels (20 and 10 percent, respectively; see Figure 1, page 5). The medium donation levels were set at 75 percent of donation levels in the high donation area, and the low donation levels were set at 50 percent of donation levels of the high donation area. In Turkish Lira (TL), the lowest price in the three areas corresponded to the smallest denomination value of preprinted HSAF receipts (receipts provided to clients who make donations). Donation levels shown in Table 1 reflect the full donation amount requested from family planning clients.

B. Operational Features

The midwives at family planning clinics explained the donation policy to clients. Full donations were collected from family planning clients willing to make them. Clients who expressed an unwillingness or inability to pay the full amount were asked to make a partial donation of any amount according to their ability. Those who expressed an unwillingness or inability to pay even a partial donation were provided contraceptive supplies for free. PHC facilities issued HSAF receipts to clients who made donations, and a copy of each receipt was provided to the Province Health Directorate.

PHC facility staff completed Client Tracking Forms (CTFs) to record information about each client encounter, including supplies issued and amounts donated. (This form was designed only for the pilot study to provide information about the distribution of client visits across donation payment categories (full, partial or exempt) and to monitor changes in volume of demand by

method, facility, and area. It will not be used during national extension of the policy. A sample copy of the CTF can be found in Annex 1.) In addition, Facility Reporting Forms (FRFs) were completed, which summarized information from the CTFs and reported the donation revenue collected (a sample FRF can be found in Annex 2).

Each PHC facility forwarded completed CTFs to their relevant HSAF branch or Province Health Directorate, along with completed FRFs and copies of the corresponding HSAF receipts issued to clients. Each HSAF branch that served as a branch for satellite clinics completed a Branch Reporting Form (BRF) (see Annex 3), which summarized information from FRFs, and submitted the BRF to the relevant Province Health Directorate. Data from these forms were then input into a database. Pilot study coordinators made visits to PHC facilities in the intervention areas to monitor and ensure proper implementation of the policy.²

The FRFs and BRFs were designed to be a regular feature of the donation policy. They will provide program managers with service-related data to monitor changes in donation patterns, by method and across regions. In addition, they will provide managers with the necessary information to revise donation levels when warranted.

In the control area, no donations were collected, and only information on the numbers of clients served and amount of contraceptive supplies dispensed by method was collected.

C. Donation Revenue Retention

The donation policy for contraceptive supplies differed from the HSAF donation policy for other health services. On average, 50 percent of donation revenue collected for other health services is retained at the facility where it is generated, 40 percent is forwarded to the central HSAF provincial branch, and 10 percent is sent to HSAF headquarters in Ankara. These retention levels, however, had to be altered for revenue from contraceptive donations to allow for the central procurement of contraceptive supplies.³ Some local retention of donation revenue was desired as an incentive for PHC facilities to implement the family planning donation policy.

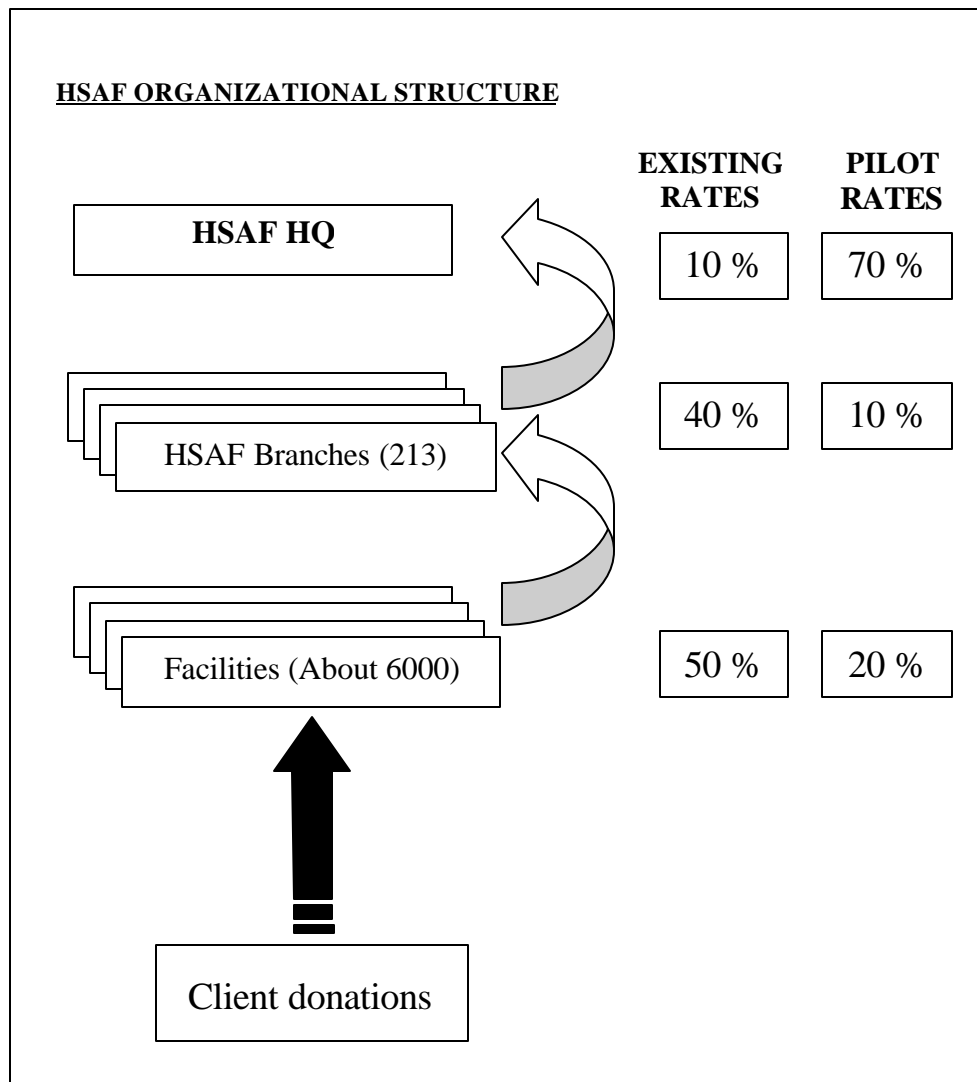
The revenue sharing plan for contraceptive donations is shown in Figure 1. In this plan, PHC facilities retain 20 percent of the revenue they generate from contraceptive donations, 10 percent is retained by the HSAF branch, and 70 percent is sent to HSAF headquarters for commodity procurements.⁴

² During these visits, individual interviews and focus-group discussions were also conducted with providers and administrators at PHC facilities and HSAF branch offices. Administrative and managerial mechanisms were assessed and satisfaction with implementation of the donation policy gauged.

³ Small quantity procurement of contraceptives by PHC facilities would carry a significantly higher unit cost than bulk procurement at the central program level. Moreover, central tracking of facility-level procurement and supply usage would be a cumbersome requirement to ensure that all areas maintained adequate supply levels. Central procurement and distribution is a better mechanism to ensure equity across areas with different abilities to raise donation revenue from family planning clients.

⁴ This revenue sharing plan for contraceptive donations does not alter the existing retention levels for donations to the HSAF for other health services.

Figure 1
HSAF Organizational Structure and Donation Revenue Retention Rates



D. Facility Participation and Client Cases Observed

Of a total of 173 PHC facilities in all four pilot study areas, 155 participated. The 18 facilities that did not participate were small health centers in remote, rural areas of the three intervention areas. They were not required to participate because of the low volume of contraceptives dispensed at the facilities and because there was little risk that clients from other PHC sites would shift their demand to these facilities. When the donation policy is expanded nationally, procedures will have to be developed to ensure that such facilities participate or that explicit criteria be developed to allow for nonparticipation. Without such criteria, there is a risk that more facilities will choose not to participate and not to implement the policy.

A total of 79,497 family planning client visits for contraceptive supplies were recorded in the four pilot study areas. However, in the database, information about the pilot area was missing for 235 cases (0.3 percent) of these cases; thus, analyses were conducted on 79,262 cases (Table 2).

Table 2
Family Planning Visits in Pilot Study Areas During the 6-month Implementation Period

Area	# of facilities	# of Cases			
		IUDs	OCs	Condoms	Total
High donation	46	2,574	3,992	7,579	14,145
Medium donation	17	750	1,948	3,906	6,604
Low donation	58	4,862	11,065	16,638	32,565
Subtotal	121	8,186	17,005	28,123	53,314
Control	34	3,668	8,995	13,285	25,948
Total	155	11,854	26,000	41,408	79,262

Donation revenue was transferred from PHC facilities to provincial HSAF branches as planned (see Figure 1, page 5). However, formal procedures for transfer of funds from provincial branches to HSAF headquarters were not finalized during the pilot study, and consequently donation revenue intended for HSAF headquarters remained in HSAF provincial branch bank accounts pending finalization of the transfer procedure. Thus, testing the administrative procedures for this transfer remains to be completed.⁵

III. Findings

Pilot study data were analyzed according to the following five topic areas:

- Client payments (percentage of full payments, partial payments, and exemptions), by pilot area, contraceptive method, and type of facility (health centers, and MCH/FP centers).
- Change in demand, by area, method, and type of facility.
- Visit continuation rates.
- Revenues generated and national revenue raising potential.

⁵ HSAF bi-laws limit the proportion of locally raised donation revenue that can be transferred to HSAF headquarters to less than the 70 percent established for the donation policy. As this report was being written, a mechanism was being tested. The GD MCH/FP issued a directive to the Province Health Director, who also serves as HSAF Province Branch Director, stating that revenue raised from the donation policy should be transferred to HSAF headquarters. If province HSAF executive boards formally consider and approve this directive, the funds could then be allowed to transfer the funds.

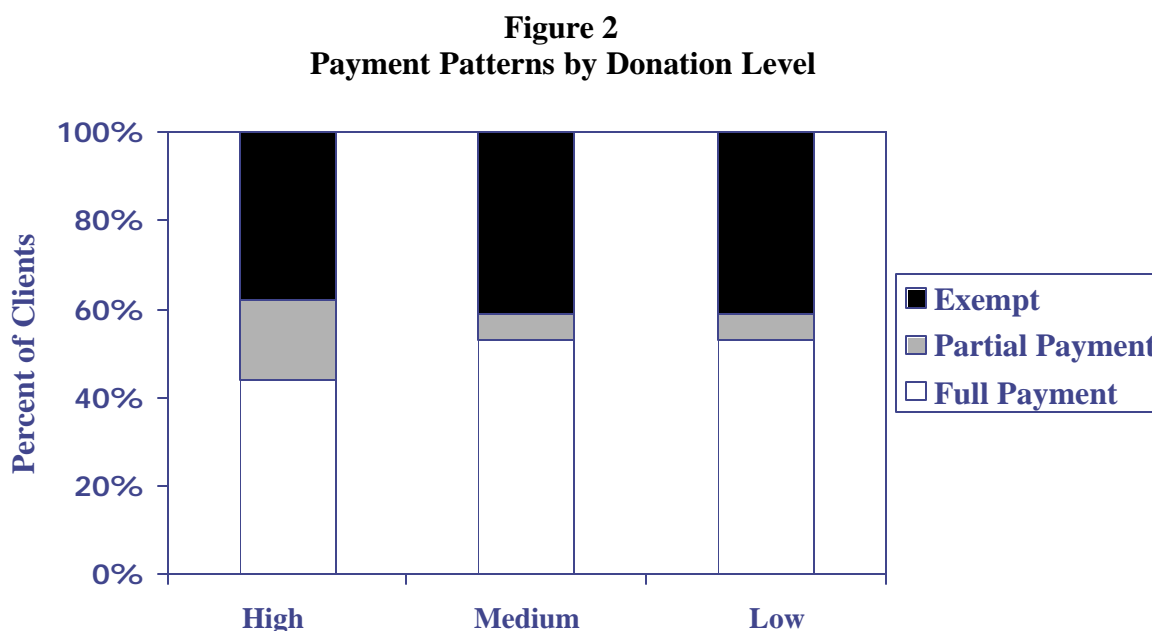
- Clients' and providers' attitudes and evaluation of the mechanism.

A. Client Payments

Data collected from CTFs recorded clients' responses to providers' requests for donations for contraceptives. Additional tables on client payment patterns can be found in Annex 4.

Payments by Area

Overall, 60 percent of clients in the three intervention areas made a donation (51 percent paid the full amount requested (full payment) and 9 percent paid less than the full amount (partial payment)) and 40 percent were exempt based on their declared unwillingness or inability to pay (Figure 2). The distribution of clients across these payment categories—full payment, partial payment, and exempt—for each donation level is shown in Figure 2.



The distribution was nearly identical in the low and medium donation areas. In the high donation area, the proportion exempted was nearly the same as in the other two areas; and overall, the proportion of clients that made some payment (either full or partial) was also nearly the same. The proportion making a partial payment in the high donation area (18 percent) was three times greater compared to the low and medium donation areas, and the proportion paying the full amount was lower (44 compared with 53 percent).

Two factors may explain the variation observed across donation levels. First, clients in the low donation area had effectively little choice of making a partial payment for condoms and OCs. The full price for one cycle of OCs and for one month's supply of condoms was set at the same amount of the lowest value of HSAF receipts (TL 250,000). In other words, OC and condom users in the low donation area effectively faced a two-tier payment option (full or none). In addition, the donation level for OCs in the low donation area provided clients with an incentive to request one cycle of pills rather than two. Whereas the price for one cycle of OCs was one-half the price for two cycles in the high and medium donation areas, the price for one cycle was one-third in the low donation area.⁶ The price for one cycle of OCs in the low donation area was very low and apparently affordable to most of those who were willing to pay.

A second factor explaining the variation across donation levels may be provider preference. During interviews and focus-group discussions, many providers expressed a preference for a two-tier donation policy (full payment or exemption) rather than a three-tier one. Some providers may have tacitly followed to a two-tiered system, especially in the low and medium donation areas; they may have felt that full donations were affordable to nearly everyone. The tendency of providers to follow a two-tiered system appears to have been stronger where donation levels were lower, thus explaining the higher proportion of clients in the high donation area who made partial instead of full donation payments.

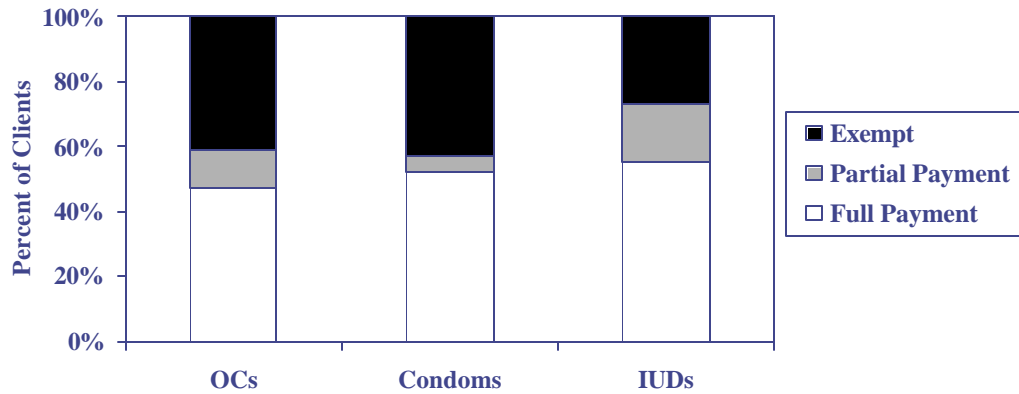
In summary, the particular donation level was not a strong factor in explaining donation patterns. All three donation levels resulted in approximately 40 percent of clients being exempt and 60 percent paying something. The high donation levels provided the greatest flexibility in tapping client's willingness to pay.

Payments by Contraceptive Method

Figure 3 shows client payment patterns by contraceptive method. The proportion of clients making either a full or partial payment was nearly the same among OC and condom clients (57 and 59 percent, respectively) and higher among IUD clients (73 percent). A higher proportion of IUD clients also made partial payments (18 percent) compared to OC (12 percent) and condom clients (5 percent). Although donation amounts for IUDs were about twice as high as the next highest priced contraceptive (two-month OC supply), a lower proportion of IUD clients were exempt (27 percent) compared to OC and condom clients (41 and 43 percent, respectively).

⁶ This feature of the donation level was unintended but was not caught until the first data from CTFs were received. At that point, the study coordinators decided it would be best not to make a mid-course correction during the implementation period.

Figure 3
Payment Patterns by Method



To better understand these patterns, trends during the six-month pilot study period were examined for each method and in each area separately. Table 3 summarizes those results.

Table 3
Trends Over the 6-Month Pilot Period in Client Payment Patterns for Contraceptives

Area	Contraceptive Method		
	OCs	Condoms	IUD
High Donation	Full payers increased (30 to 44%)	Full payers increased (33 to 44%)	Full payers remained constant (51 to 54%)
	Exempted decreased (51 to 32%)	Exempted decreased (54 to 42%)	Exempted increased (15 to 20%)
	Partial payers remained constant (19 to 23%)	Partial payers remained constant (13 to 14%)	Partial payers decreased (34 to 26%)
Medium Donation	Full payers increased (44 to 55%)	Full payers increased (39 to 55%)	Full payers decreased sharply in the last 2 months (60% to 43%)
	Exempted decreased (52 to 38%)	Exempted decreased (59 to 42%)	Exempted increased (20 to 33%)
	Small increase in partial payers (4 to 7%)	Partial payers remained low (2 to 3%)	Partial payers remained constant (20 to 24%)
Low Donation	Patterns and proportions similar to medium donation area	Little change in patterns (full payers 55%, exempted 43%, partial payers 2%)	Full payers decreased (61 to 48%)
			Exempt increased (21 to 41%)
			Partial payers decreased (18 to 11%)

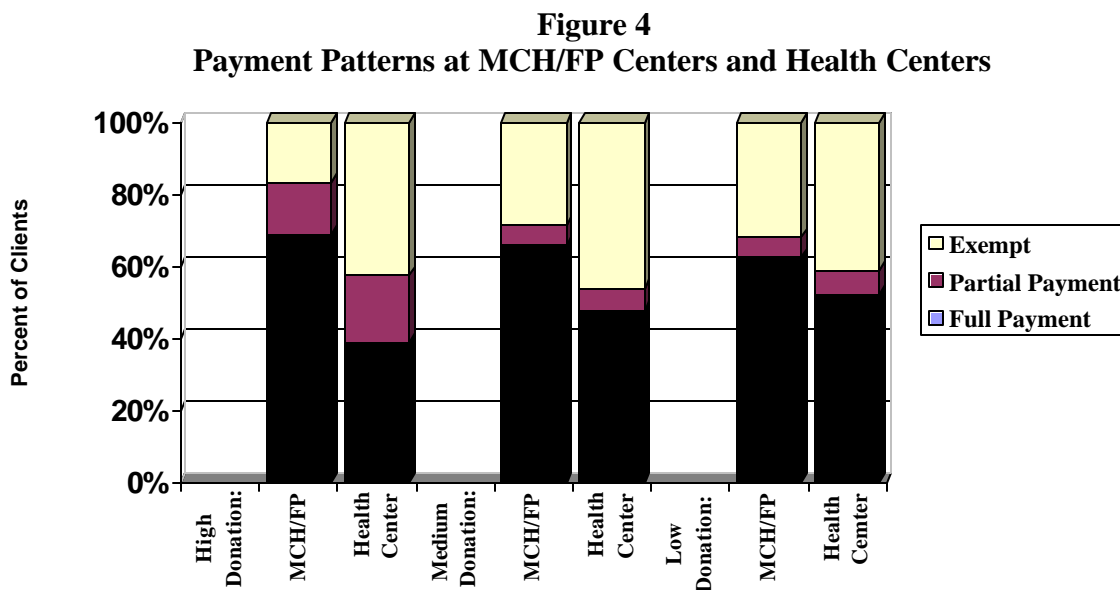
Several trends and comparisons are noteworthy. First, while the proportion of OC and condom clients who made full payments increased over time in the three intervention areas, the proportion of IUD clients who made full payments did not. The proportion of IUD clients who made full payments declined by more than 10 percentage points in the low and medium donation areas, falling in both to below 50 percent. On the other hand, the proportion of IUD clients in the high donation area who made full payments remained relatively constant, above 50 percent. Changes over time in the proportions making partial payments were considerably smaller, especially for OCs and condoms.

Trends in exemptions were opposite those for full payment. The proportion of OC clients exempted decreased in all three intervention areas, and the proportion of condom clients exempted decreased in the high and medium areas. Considered alongside the increasing trends in the proportion of OC and condom clients making full payments, it appears that many clients were reluctant at first to pay the increased donation price; however, some eventually accepted the new policy and were willing to pay.

Among IUD users, the opposite occurred. Over time, more clients over time elected not to pay the new donation prices. It is unclear why this trend occurred only in the medium and low donation areas. In the high donation area, there was actually an increase in the willingness of clients to make full payments. There may be unmeasured differences in providers' behavior. This does suggest, however, that the price set in the high donation area was not so high as to produce a greater reluctance to pay (full or partial) among IUD clients.

Payments by Type of Facility

Figure 4 compares the distributions of client payment categories at the types of facilities where the donation policy was implemented: MCH/FP centers and health centers.



MCH/FP centers are larger than health centers and fewer in number. (There are only two MCH/FP centers in the low donation area, and one each in the high and medium donation areas.) MCH/FP centers are compared to urban health centers only, since MCH/FP centers are located only in urban areas.

In each of the three intervention areas, a higher proportion of MCH/FP center clients, compared to health center clients, made full donations for contraceptive supplies, while a lower proportion were exempted. In comparing only health centers across the three intervention areas, the proportion of full paying clients decreased as the donation price increased across the three donation levels. This was an expected occurrence; as donation prices rise, more clients would be expected to offer a partial donation or choose to be exempted. In contrast, a greater proportion of clients at MCH/FP centers across the three intervention areas paid the full donation even as the donation price increased.

The reason that MCH/FP centers were able to collect donations from a greater percentage of client donations is unclear. MCH/FP centers are said to serve a better-off clientele than health centers. In addition, MCH/FP centers are generally perceived to provide better quality services.⁷ Clients may be willing to pay more for a perceived higher quality of services. That only four MCH/FP centers participated in the pilot study also suggests that differences may be more related to the characteristics of specific facilities, such as staff attitudes, behavior, and experience, rather than to client-centered factors. Staff at MCH/FP centers have been collecting donations from clients for IUD insertions for at least two years, whereas the task of collecting donations has been new to most staff at health centers.

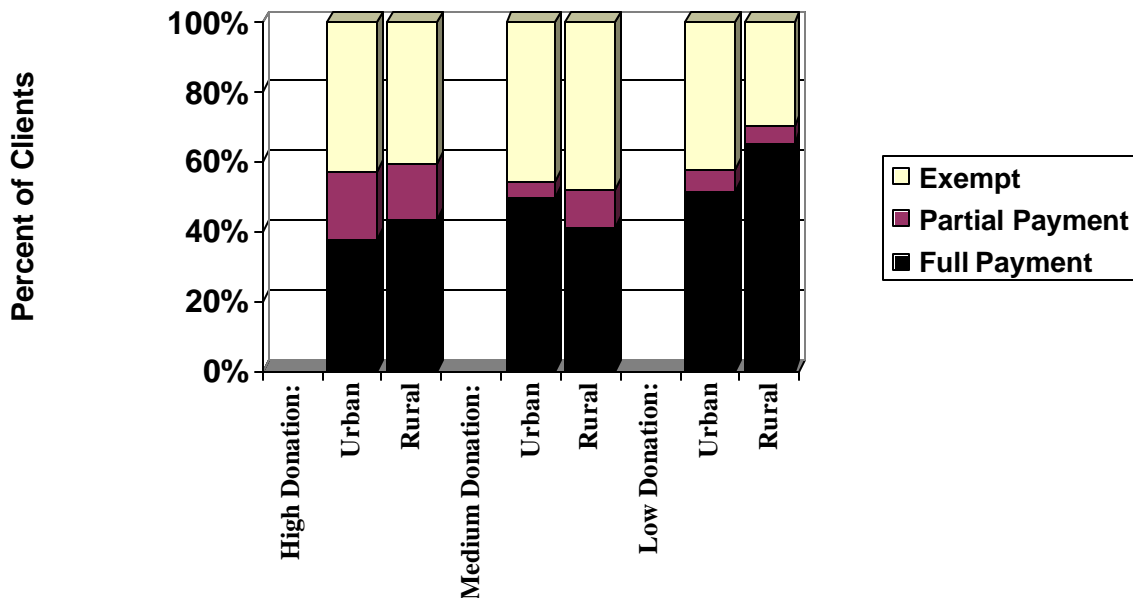
Regardless of the reason, health centers provide a much greater proportion of family planning services nationwide than do MCH/FP centers; therefore, it may be more important to compare the results of health center performance across the three intervention areas. Health centers in the high donation area performed as well as health centers in the medium and low donation areas in terms of the total proportion of clients making either a full or partial payment. Fifty-eight percent of health center clients in the high donation area made some donation, compared to 54 percent of clients in the medium donation area and 59 percent in the low donation area.

Payments by Urban/Rural Location

In Turkey, the poor live in both urban and rural areas, but the rural poor may have less access to cash and have fewer private sector alternatives to MOH PHC facilities for contraceptive supplies. Thus, it is of interest to compare the experience of rural and urban health facilities in applying the donation policy. Of the two types of facilities participating in the pilot study, only health centers exist in rural areas, and MCH/FP centers in general perform differently in comparison to health centers. Therefore, in comparing urban and rural performance, the analysis is restricted to health centers (Figure 5).

⁷ Personnel communication; MOH GD for MCH/FP senior staff.

Figure 5
Client Donation Payment at Urban and Rural Health Centers



No clear pattern emerged from the comparison of the distribution of donation payment categories—full payment, partial payment, or exempt—across the three pilot areas. A higher proportion of rural clients in the low donation area made full donations, whereas the opposite was true in the medium donation area. In the high donation area, the pattern was similar to the low donation area, with a slightly higher proportion of rural clients making full donations compared to urban clients. A higher proportion of both rural and urban clients in the high donation area made partial payments, confirming the finding that the partial payment option was more important where donation prices were higher.

Rural health center clients more often make full donations for their contraceptive supplies. The explanation for this may lie in the payment patterns for OCs. There was a greater propensity for urban OC clients to be exempt from donation payments than rural clients (42 percent for urban OC clients to 33 percent for rural OC clients) possibly due to staff familiarity of clients' ability to pay, making it more difficult for nonpoor rural clients to declare an exemption. It may also be that the mix of clients in rural health centers is less poor, since fewer private sector options for contraceptive supplies may be available (being either absent or, among existing options, less confidential), thus driving the poor and the nonpoor alike to the public health center. If the former is true, it suggests that the targeting of subsidies is less effective in urban health centers.

B. Change in Demand for Contraceptive Supplies

Background for Demand Analysis

Policymakers are concerned about the impact of the donation policy on contraceptive demand for several reasons. First and most important is the potential negative impact on women's health.

Women who forego modern method contraception rather than pay for the supplies are at greater risk for unwanted pregnancies. While the donation policy was designed to allow clients to decide whether and how much to donate for supplies, evidence from interviews and focus groups with providers suggests that some clients may have felt coerced into making a donation or were hesitant to express their unwillingness to pay. Contrary to instructions, some providers implemented the donation policy as if it were based on *ability* rather than *willingness* to pay, adopting a questioning/negotiating stance during client encounters. Also, where a client's hesitation to request or declare exemption coincided with his/her actual low economic status, some clients may have discontinued modern method use. Since donation levels in all intervention areas were set below prices for the lowest priced private sector alternatives, these clients were unlikely to have shifted to the higher priced alternative sources.

Other clients who felt they were able to pay a donation may also have left the public sector program to obtain contraceptive supplies elsewhere. For some of these clients, the new donation price at public clinics may have been close enough to private sector prices to have increased their incentive to shift to a private source.

Clients who shifted their demand for contraceptive supplies from public to private sources are less of a concern here. Assuming private supplies are at least of equal quality to the public supplies, those clients' needs are still being met. However, clients who decided to forego modern method contraceptive use altogether as a result of the donation policy are of great concern. There is evidence suggesting that the donation policy did result in a decrease in demand for OCs and condoms (but not IUDs) by clients at public clinics. Information was also collected on the demand for contraceptives at public hospitals (including MOH hospitals and hospitals operated by the quasi-public social insurance organization, SSK) to determine how much demand, if any, shifted to these facilities. Pilot study resources were, however, insufficient to determine how much demand did shift to private sector supply sources, to nonmodern method use, and to nonuse. Research on these questions should be undertaken as soon as possible.

In recognizing that changes in demand may be attributable to factors other than the donation policy, an effort was made to delineate those factors. These included special information, education, and communication (IEC) activities to promote the use of services, changes in in-service training activities (i.e., on family planning counseling, IUD insertion, or the use of new methods such as injectables), and changes in staff turnover or deployment patterns. Changes in the availability of commodities, including commodity stockouts, were also investigated. Study coordinators visited each intervention area before and during the six-month pilot study period to collect information on these potentially confounding factors. Information was collected from individual facilities as well as from national and provincial program administrators and NGOs active in the family planning sector.

The three intervention areas are located in USAID priority provinces, where activities were of limited nature and judged not likely to have had a significant impact on demand, especially in the short term. An IEC training program was to have taken place in these USAID priority provinces, but during the pilot study period the program did not expand beyond a training-of-trainers (TOT). These USAID priority provinces are also the target of a postabortion and postpartum family planning initiative. Yet by the end of the six months, the only activity conducted was a

postabortion training workshop in one hospital in Adana (and this activity occurred late in the pilot study period, October 2001). The activity's impact occurred in the final month of the pilot study and was confined to the targeted hospital.

None of the alternative factors investigated were judged to have had a significant impact on family planning use in the intervention areas before or during the pilot study period. Other unmeasured characteristics of the environment that affect demand were likely to be present; however, there was no evidence that such factors existed differentially across all four pilot areas. Therefore, any observed change in demand during the pilot study period was likely attributable to the donation policy.

Measurement of Demand

Two choices existed for measuring demand in the four areas: (1) number of users or visits, and (2) volume of commodities dispensed to users. Volume of commodities was chosen based on the following rationale.

The current national program service statistics from public sector outlets report, by contraceptive method, the number of visits where contraceptive supplies have been dispensed. However, the amount of commodities dispensed per visit is not standardized, even at the facility level. Therefore, in terms of commodities dispensed, not all visits are equal. This is especially true in comparing the periods before and during the pilot study period. Donation prices were established for specific units of commodities (e.g., 12 condoms, one or two cycles of pills); also, participating facilities were strongly encouraged to dispense contraceptives in these prescribed units only.⁸ The donation policy did have a standardizing effect on the dispensing practices of providers in the three intervention areas. For OC and condom users, this generally required clients to make more visits to meet their annual supply needs.⁹ Consequently, comparing visits before and during the pilot study period would not be an accurate measure of the change in demand. Volumes of contraceptives dispensed would be more accurate.

To assess changes in demand, consumption figures recorded for the six-month pilot study period were compared with figures for the corresponding six-month period in 1999. Changes in demand in each of the three intervention areas were compared with changes in the control area and with each other to estimate the effect of the different donation levels. Information for these comparisons was obtained from routine program service statistics.

Findings from Analysis of Demand

Figures 6, 7, and 8 show the changes in demand in each area in terms of total amount of supplies dispensed to clients. The three leftmost bars on the three figures represent the percentage change

⁸ An existing ministerial decree required that contraceptives be dispensed in these specific quantities, but it has rarely been enforced. Providers have tended to dispense a greater quantity of supplies, compared to the standards set forth in the decree, based on the stated or assumed needs of clients.

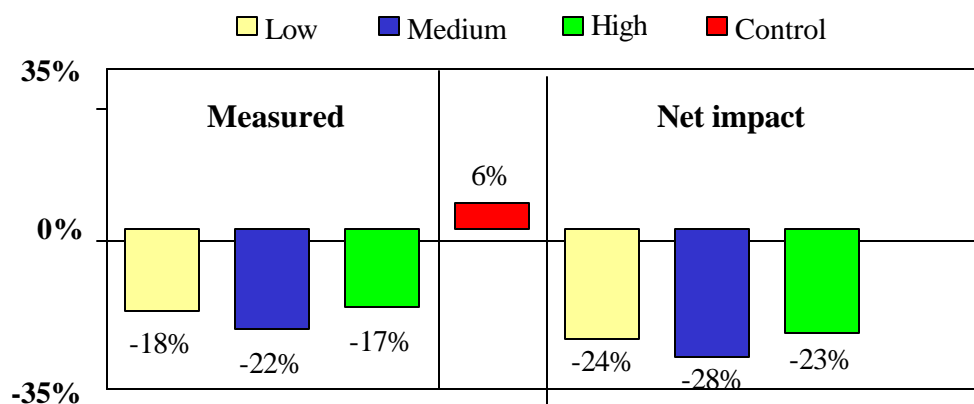
⁹ For example, prior to the pilot study, OC users who were dispensed on average a three-month supply per visit would have needed to make only four visits per year. Under the donation policy, pills are dispensed every two months; thus, OC users would have to make six visits per year to maintain the same supply.

from 1999 to 2000 in the number of supplies dispensed in each of the three intervention areas. The middle bar shows the same change for the control area. The three rightmost bars show the percentage change in each of the three intervention areas represented as a *net* change, the difference between the observed change in each intervention area (shown in the leftmost bars) and the observed change in the control area.

Demand for OCs

The three intervention areas experienced a decline in demand for OCs (Figure 6). Demand for OCs increased slightly in the control area, but declined by a nearly uniform rate in each of the three intervention areas. Assuming that in the absence of the donation policy the intervention areas would have experienced a similar increase in OC demand; the calculated net declines in demand in the intervention areas¹⁰ were 23, 28, and 24 percent in the high, medium, and low donation areas, respectively. Thus, implementation of the donation policy did significantly affect the demand for OCs. However, clients appear to have been influenced by the fact that a donation was being requested more than by the amount of the donation. In this respect, there is clear justification for selecting the high donation level for OCs during a national expansion, since selecting a lower donation level would reduce neither the loss of clients nor the total revenue collected.

Figure 6
Change in Demand for OCs from 1999 to 2000 (June–November)

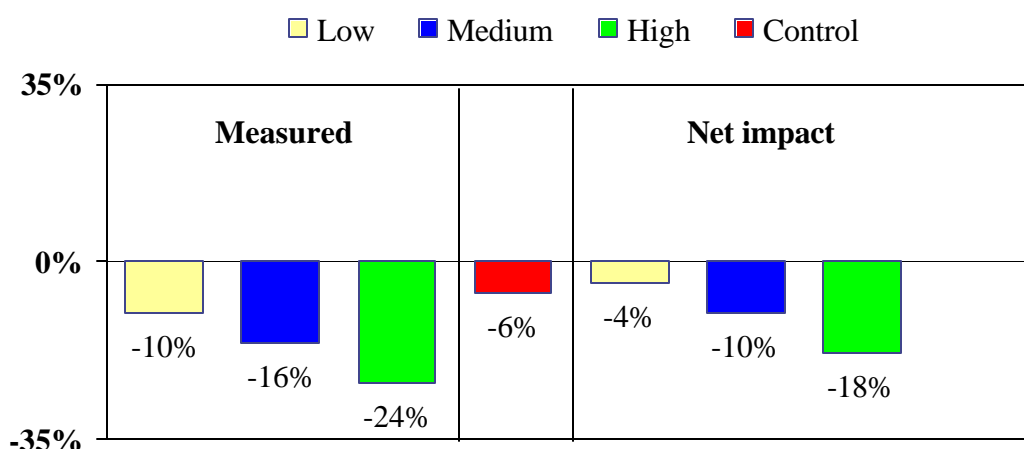


Demand for Condoms

Demand for condoms also declined during the pilot study period in the three intervention areas (Figure 7).

¹⁰ The net decline is the difference in the observed change and what would be expected in the absence of the pilot intervention.

Figure 7
Change in Demand for Condoms from 1999 to 2000 (June–November)



In contrast to demand for OCs, demand for condoms appears to have been price-sensitive; that is, the higher donation price, the greater the drop in demand. The largest net decline occurred in the high donation area (18 percent), the second largest net decline in the medium donation area (10 percent), and the lowest in the low donation area (4 percent). The difference among these percentage changes is statistically significant. In the case of condoms, clients responded both to the donation policy and to prices.

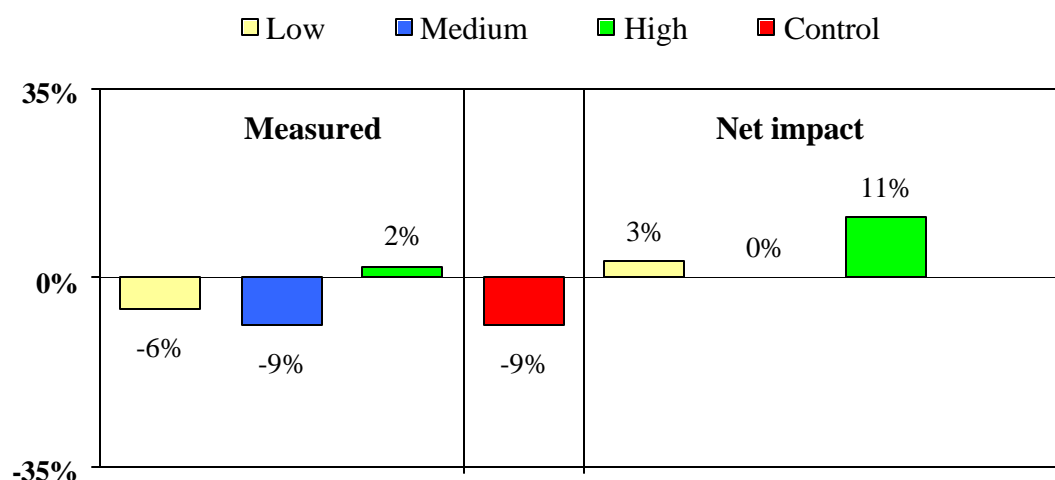
Demand for condoms may be price-sensitive while demand for OCs is not because of the difference in the size of the gap between the donation price and the lowest price private sector alternative. The full donation price for one month's supply of condoms and OCs was the same in each intervention area. However, the difference between the full donation price for OCs and the lowest private sector price was lower than the difference for condoms (see Table 2, page 6). For OC clients, it may be that the difference between donation and commercial prices in the intervention areas remained close enough to cause the same proportion of clients to switch to a private sector source. The lowest commercial price for a one-month's supply of condoms was 63 percent higher than for OCs (\$2.69 to \$1.65, respectively), and the difference between donation and commercial prices was therefore greater for condoms. In the low donation area, the price difference for condoms was sufficiently large to produce only a small decline in demand at public clinics. With higher donation prices, the price difference was lower, reducing the benefit to clients of continuing to use public clinics.

Demand for IUDs

In contrast to OCs and condoms, net demand for IUDs did not decrease in any of the intervention areas (Figure 8). In fact, it increased by 3 and 11 percent in the low and high donation areas, respectively. There was no change in the medium donation area, relative to the control area. Again, an explanation may lie in the comparison of donation prices with the lowest private sector

price alternative. For IUDs however, one must look beyond the donation prices for the device itself. As noted earlier, in addition to the donation price for the device, clients must also pay a donation price for its insertion at public clinics. Prior to the pilot study, the average donation price at public clinics for IUD insertion was about US\$1.50. Adding to that the new donation prices for the device, the total price (IUD device, plus insertion donation) to clients during the pilot study was between US\$3.75 and \$6 in the three intervention areas.¹¹ The lowest price for an IUD insertion from a private source in Turkey was approximately US\$25 or about US\$19 more than the total donation price in the high donation area. This large difference was sufficient to discourage consumers from switching to a commercial sector alternative.

Figure 8
Change in Demand for IUDs from 1999 to 2000 (June–November)



In summary, the donation policy had the greatest negative impact on the demand for OCs, and that impact was uniform across the three intervention areas. This change was coincident with the lowest difference between the donation price and the closest private alternative price among the three contraceptive methods studied. The impact on condom demand from public clinics was increasingly large at higher donation levels and as the price difference between public clinics and private alternatives decreased. No impact was observed for IUDs at any donation price level, which was coincident with much larger differences in prices for commercial sector alternatives.

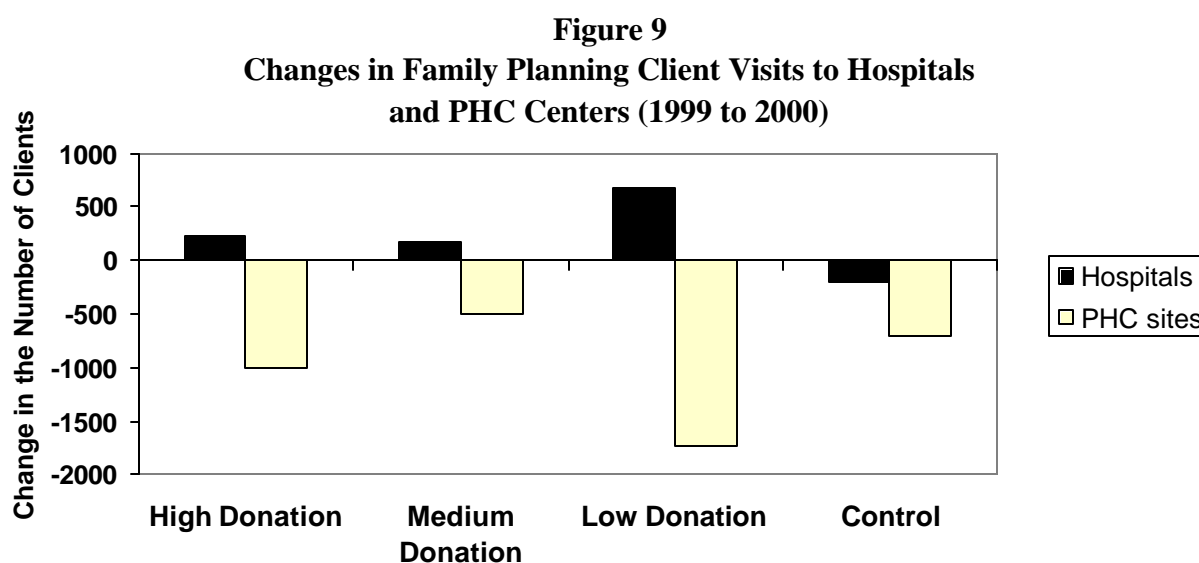
Source and Method Shifts Among Family Planning Clients

As noted earlier, public sector family planning clients may react in different ways to these new donation levels. They may shift to alternative sources for their contraceptive supplies, change to different modern methods, or abandon modern method use altogether (the exemption aspect of

¹¹ In the control area, there was no new donation price for the IUD and clients continued to pay only the donation for the insertion service.

the donation policy was designed to prevent this). This report first considers evidence from the pilot study for shifts in sources of supply.

Some clients who considered themselves able and willing to pay the donation price may have found the new prices sufficiently close to the price of a private alternative and switched to that source. Others may have switched to a public sector source not participating in the pilot study, such as a hospital.¹² Figure 9 compares the change in the number clients receiving contraceptives at hospitals with the change at PHC facilities in the pilot areas.



Hospitals account for a low proportion of family planning services delivered in Turkey. For condoms and OCs, less than 10 percent of all commodities distributed through the MOH health care delivery system are distributed at hospitals. The proportion is higher for IUDs, as high as 24 percent (in the high and medium donation areas), but still a low proportion relative to the total number of IUDs. The data shown in Figure 9 represent aggregate changes in the volumes of clients served, including OC, condom, and IUD users who received supplies.¹³

Comparing the small decline in demand at PHC facilities in the control area relative to the larger declines in the three intervention areas, a donation policy effect is visible. It is also clear that the volume of services provided by hospitals for all three methods did in fact increase in the three

¹² SSK hospitals were included in this category. They operate similar to MOH hospitals and charges for services are low or nonexistent for SSK beneficiaries. However, since SSK procures few contraceptive commodities, any observed increase in demand for contraceptive supplies at hospitals was likely to occur at MOH hospitals, which are supplied by the MOH central warehouse.

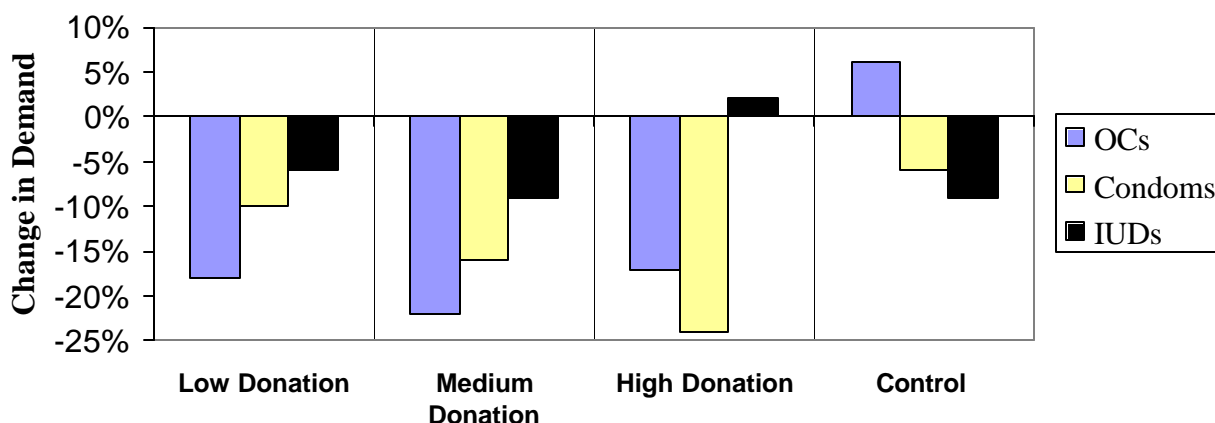
¹³ Pilot study data were recorded in terms of number of visits. During the pilot study period, most OC and condom clients visited health care facilities several times for a resupply. For this analysis, OC and condom visits were converted to the number of clients, based on an average of three visits per client during the six-month study period, so that data on IUD clients could be included in the analysis. Figure 9 reflects these conversions.

intervention areas. In the control area, the number of clients served at hospitals also increased for OCs and IUDs; however, the increases were generally small. There was a small proportional decline in the number of condom clients seen at hospitals in the control area. Due to the large number of condom clients (about three-quarters of all clients seen in hospitals in the control area), the small decline offset the small (but proportionally larger) increases in OC and IUD clients.

These patterns provide only weak support for the contention that changes in hospital services were different in the intervention areas. However, even if all the increases observed at intervention area hospitals are assumed to be attributable to clients seeking to avoid the donation policy at PHC facilities, between 61 and 77 percent of the decline in the number of clients served at PHC facilities is still unexplained. Moreover, the greatest increase occurred in hospitals in the low donation area. Still, the possibility that a real shift toward hospitals cannot be ruled out; as more clients, especially those living closer to hospitals, realize that the donation policy is not being implemented there, such a shift may become more apparent. Therefore, the donation policy should be extended to include all public hospitals (see Section IV, Recommendations).

To see whether clients switched to different modern methods as a result of the policy, the relative changes in demand for OCs, condoms, and IUDs were examined within each intervention area (Figure 10).

Figure 10
Changes in Demand for Contraceptives Supplies
by Intervention Area



It is unlikely that clients in the three intervention areas would have changed from OCs to condoms or vice versa as a result of the donation policy, since a one-month supply for both methods was priced identically. Indeed, as noted earlier, demand for both methods declined significantly in the intervention areas relative to the control area. The possibility that some shift from OCs and condoms to IUDs occurred cannot be ruled out, particularly in the high donation

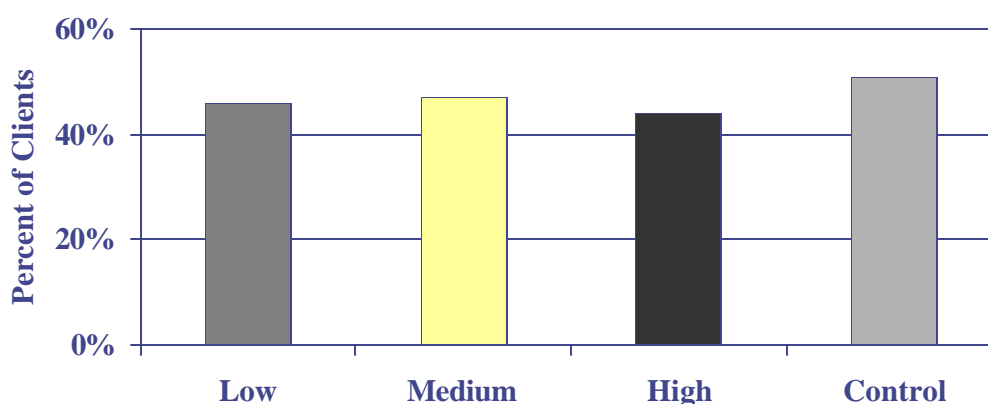
area. In the control area, demand for IUDs declined by 11 percent, a larger proportional decline than in any of the intervention areas. In the high donation area, an increase in demand for IUDs was actually observed.

Some consumers who felt they were unable or were simply unwilling to pay for OCs or condoms may have opted for an IUD instead. This would most likely be the case among clients who wished to limit their fertility (the most appropriate reason for using an IUD), but who had been using a supply method. In the case of public sector health care facilities, some family planning clients may well have done this when OCs and condoms were universally free, while an insertion donation was requested for IUD users. Under the new donation policy, the annual cost of OC and condom supplies approached or exceeded the donation price for an IUD. However, in the high donation area, even if one assumes that all of the observed increase in IUD demand was from clients who switched from OC or condom use, this accounts for no more than 28 percent of the decrease in demand for OCs and condoms.¹⁴

Visit Continuation Rates

Analysis of the number of visits made for contraceptive supplies or of the number of contraceptives dispensed may underestimate the effect of the donation policy on demand. The policy may have had a greater impact on clients who had previously used a PHC facility compared to clients seeking contraceptive supplies at a PHC facility for the first time. To evaluate this possibility, study evaluators compared the proportion of clients making revisits for OCs in the four pilot areas (Figure 11).¹⁵ Clients who obtained OCs during the first month of the pilot study (June 2000), and who also obtained a resupply at any PHC facility during the ensuing months of the study, were defined as having made a continuation visit.

Figure 11
Revisit Rates for OC Clients During the Pilot Study Period



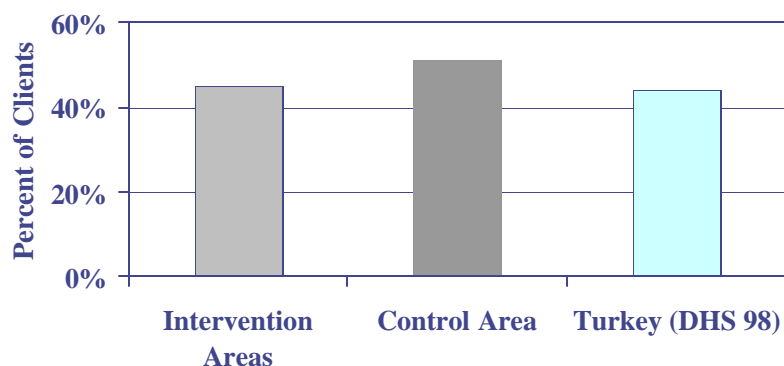
¹⁴ Using net changes in demand (observed change in demand in the high donation area, minus the change observed in the control area), there were 365 fewer OCs users and 610 fewer condom users, compared to a total increase of 275 IUD users (259 more at PHC facilities and 16 more at hospitals).

¹⁵ Condoms were not studied because condom users in Turkey are known to patronize public and private sources interchangeably, whereas OC users tend to more consistently patronize one source or the other.

The difference among revisit rates for the three intervention areas (46, 47, and 44 percent for low, medium, and high donation areas, respectively) was not statistically significant. However, the revisit rate in the control area (51 percent) was a significantly higher. Before concluding that the donation policy was associated with this difference, the higher degree of migration experienced in the three intervention areas should be considered. The influx of migrant workers is greater in the three intervention areas than to the control area, as is the outflow of people to cooler highlands during the hot summer months. However, the nearly equal rates in the low, medium, and high donation areas may mean that donation levels were not a significant factor in OC revisit rates.

Revisit rates were also compared to OC continuation rates calculated from the national 1998 Demographic and Health Survey (DHS) (Figure 12). Revisit rates in the intervention areas that fell below the national continuation rate for OCs would show that the donation policy had a negative effect on continuation rates. This, however, was not the case. Revisit rates in the three intervention areas (shown in Figure 12 as an aggregate rate) were at nearly the same level as the national continuation rate. That the revisit rate in the control area was higher than the national rate suggests that other factors besides the donation policy are causing better performance there compared to the intervention areas.

Figure 12
Revisit Rates for OC Users in Pilot Study Areas (June-November 2000)
and OC Continuation Rate for Turkey (DHS 98)



C. Revenues Obtained in Three Intervention Areas

Revenues from contraceptive donations at pilot facilities were transferred to provincial HSAF branches (Table 4). During the six-month pilot study period, US\$33,055 was collected from clients for contraceptive supplies. Eighty percent (US\$27,950) was transferred to provincial HSAF branches, as called for under the donation policy. Ninety percent of this amount (US\$23,800) was set aside for transfer to HSAF headquarters. Based on these results, and those

from the demand analysis presented earlier, forecasts were made as to the potential for annual revenue collection in an expanded implementation of the donation policy. Results from these projections are considered in the following section.

Table 4
Total Donation Revenue Transferred to Province HSAF Branches
during the Pilot Study Period

Areas	Total Revenue (Billion TL)
Low Donation	6.62
Medium Donation	2.06
High Donation	7.27
TOTAL	15.95 (US\$23,800)¹⁶

National Revenue Projections

Two sets of scenarios were forecasted. The first set was based on the assumption that the donation policy will be expanded nationwide, except in the 25 Eastern provinces.¹⁷ Those provinces have a higher incidence of poverty, and modern contraceptive use is considerably lower than the national average. The government will create a special investment zone in these provinces to attract intensive development investments. No donations will be permitted for public services within these zones.

The second set was based on the assumption that the implementation of the donation policy will be expanded to only the 16 most populous provinces in Turkey, including Adana and Icel, the sites where the pilot study was conducted.¹⁸ This assumption was based on technical and political feasibility of expanding implementation. These 16 provinces include about one-half of the nation's population and, due to disproportionate high contraceptive prevalence rates in these provinces, it is estimated that they constitute about 80 percent of the donation policy's national revenue-raising potential. Additional assumptions common to both scenario projections are:

- Estimated annual consumption of contraceptive commodities is based on the actual volume of commodities consumed in 2000.

¹⁶ At the end of the pilot study period (December 2000), the exchange rate was approximately TL 670,000 to US\$1. Since then, the value of the TL has declined sharply, which will affect the quantity of contraceptives that can be purchased with donation revenue, since their prices are closely tied to the U.S. dollar.

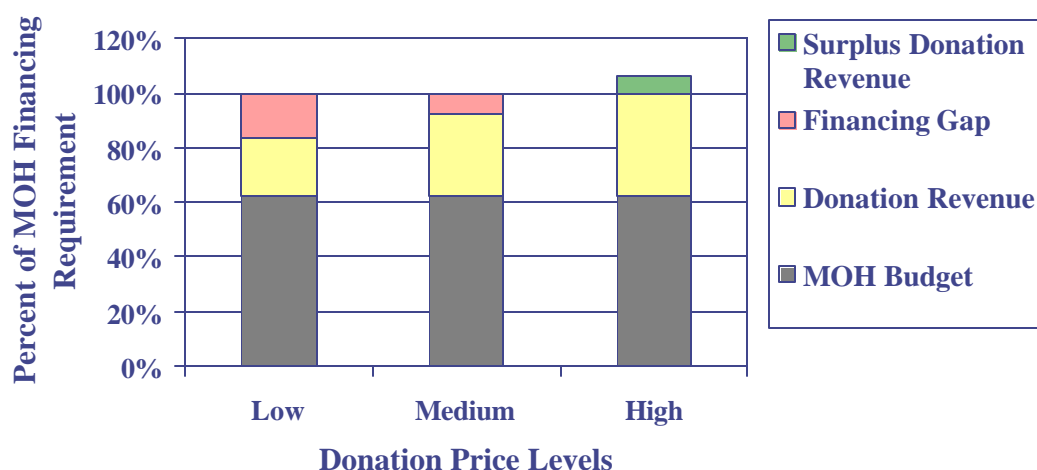
¹⁷ There are 81 provinces in Turkey.

¹⁸ As this report was being written, the MOH designated 16 provinces for donation policy expansion. This decision must be officially approved.

- The total annual MOH financing requirement for OCs, condoms, and IUDs is US\$4 million.¹⁹
- Seventy percent of the total contraceptive donation revenue generated by facilities is centralized at HSAF headquarters for contraceptive procurement.
- Distribution of donation payment categories (full payment, partial payment, and exemption) for each method and each pilot area is the average distribution observed across the six-month pilot study period.²⁰

The first set of forecasts is shown in Figure 13. If implementation of the donation policy were expanded to the 56 non-Eastern provinces, only the donation prices of the high donation area would raise sufficient revenue to close the gap between MOH budget resources for contraceptive purchases and annual needs. In fact, the high donation prices would generate a small surplus (6 percent), which could be used to improve the national stock cushion of contraceptives.²¹ The low donation scenario (that is, if the donation amounts were set at those prevailing in the low donation area in all expansion provinces) would result in a financial gap of 17 percent. The medium donation scenario would result in a gap of 8 percent.

Figure 13
Revenue Raising Potential of Donation Policy Expanded to 56 Non-Eastern Provinces



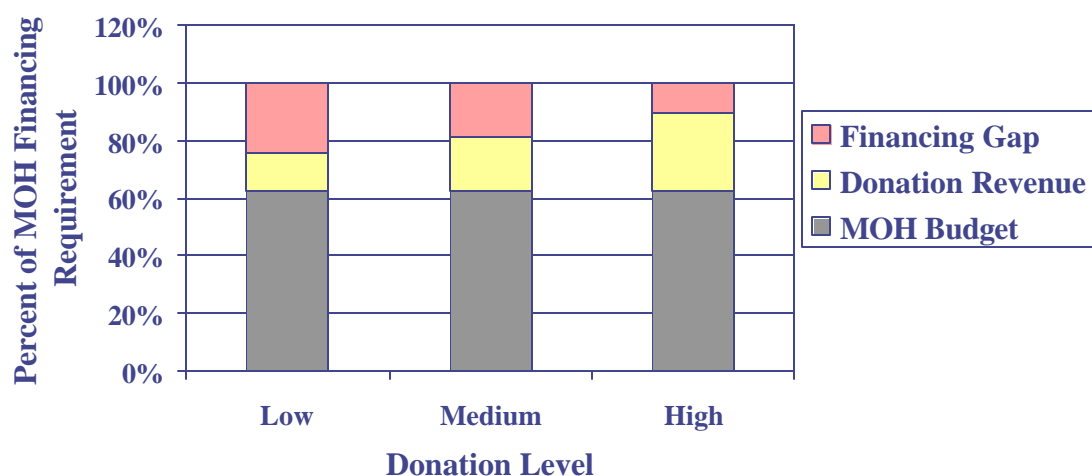
¹⁹ Results of the pilot study suggest that, due to declining demand for OCs and condoms, the MOH's total need for resources to procure contraceptives may in fact decline. However, modern method contraceptive prevalence may rise, especially among those currently having an unmet need for contraceptives (a high-priority target group for the MOH), offsetting any potential decline driven by the donation policy. Furthermore, because of a short study period (six months), care must be taken in interpreting the observed decline in demand until more experience with the policy is gained.

²⁰ This conservative assumption likely underestimates the revenue raising potential of each scenario since the proportion of clients exempted from donation payment declined for OCs and condoms in the six-month pilot study period, while the proportion paying the full donation amount increased.

²¹ During the transition to national self-reliance in contraceptive supplies for the public sector program, the national stock cushion in MOH warehouses has fallen below their "safe" standard of a 15-month supply.

The second set of forecasts is shown in Figure 14. If implementation of the donation policy were expanded to 16 of the most populous and better-off provinces, none of the donation levels would raise sufficient revenue to close MOH's contraceptive financing gap. The gap is smallest (11 percent of financial requirements) where the donation prices for the expansion are set at levels from the high donation area. The gap is 19 percent for the medium donation price scenario and 25 percent for the low donation price scenario.

Figure 14
Revenue Raising Potential of Donation Policy Expanded to 16 Populous Provinces



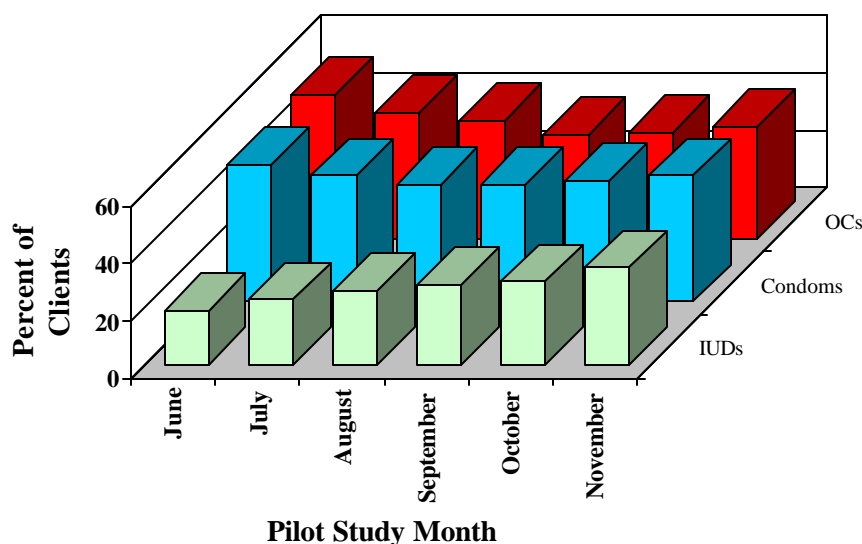
D. Clients' Attitudes Toward the Donation Policy

Clients' reactions to the donation policy were assessed through interviews with service providers during monitoring visits to PHC facilities. Because IUD users were accustomed to making donations for services (for insertion, not the device) before the pilot study period began, they only questioned the increase in the donation amount, not the donation policy itself. Generally, clients attending PHC facilities expected to have to pay a donation for IUD insertion, and they arrived with sufficient money to pay the donation for both the insertion service and the device. In contrast, since donations for OCs and condoms were new, providers reported early in the pilot study period that more clients seeking these methods stated that they were not carrying sufficient cash to pay the donation. Providers also reported that most of these clients came prepared to make donations at their next revisit and that, indeed, most paid a donation on subsequent visits.

Trend data on the distribution of client donation payments across full payment, partial payment, and exempt categories support providers' claims that the proportion of clients who declared an exemption from paying decreased over time (Figure 15). The proportion of exempted OC and condom clients fell steadily in the first four months of the pilot study period before leveling off. The proportion of clients making either a full or partial payment increased from 50 to 61 percent in the six-month pilot study period, with nearly all this increase attributable to an increase in the proportion of clients paying the full donation. The trend among condom clients is similar,

although not as pronounced. The proportion of those exempted declined in the first three months before leveling off, while the proportion making a full or partial payment increased from 52 to 58 percent in the six-month pilot study period. These trends indicate a maturation effect; clients initially were unwilling or unprepared to pay the new donation; however, as they became familiar with the policy, they were increasingly willing to make a donation.

Figure 15
Trends in the Proportion of Clients Exempted from Donation Payment



The trend among IUD clients stands in contrast to OC and condom clients. The proportion exempted increased steadily during the pilot study period, while the full and partial payment proportions decreased. However, by the end of the six-month period, the proportion of exempted IUDs clients was still below the proportion of both OC and condom clients. No evidence that these trends are explained by seasonal variation exists. Maturation of providers, as well as clients, familiarity, and comfort with the policy and its implementation may have affected clients' behavior.

It is important to assess the implications of these trends on the donation policy's revenue raising potential. If the trends continue, then the revenue raising potential is greater for OCs and condoms, but lower for IUDs. However, if these trends have indeed leveled off, as appears to be the case for OCs and condoms, then the revenue-raising potential is greater than that forecasted previously in this report.²²

In summary, providers reported that clients' reactions to the donation policy were generally favorable, although they did frequently ask questions about its rationale. Providers said that while some clients expressed opposition to the policy, none exhibited antagonism or chose to

²² Recall that the assumed distribution of payment categories used for that analysis was the average distribution across the pilot study period, meaning that a greater proportion of clients were assumed exempt than was indeed the case at the end of the period.

leave without the supplies they sought. Providers speculated that this was due to their responsiveness to clients' concerns when they arose and their willingness to answer questions.

E. Providers' Attitudes Toward the Donation Policy and its Procedures

Service providers' attitudes and behaviors in response to the donation policy were assessed during eight focus-group discussions with physicians and midwives in the three intervention areas. Providers were asked their opinions on the impact on clients' contraceptive use, the implementation process for the donation policy, and operational procedures.

Client Responses

Providers reported that they did not perceive any change when asked about the impact the donation policy was having on client demand for contraceptives at their facilities. When shown evidence that the volume of commodities dispensed had declined, providers contended that this could be explained by the decline in inefficient use of commodities by clients. For example, providers believed that clients had become more aware of the value of their contraceptive supplies, were now buying only what they needed, and were taking care to properly store their supplies. To a lesser extent, providers attributed the decline to more effective stock management techniques. Many providers also expressed skepticism that some clients were abandoning their clinics for other supply sources or discontinuing modern method use. They believed that exemption was being implemented as intended, exempting clients who expressed an unwillingness to pay. In addition, providers believed that any tendency among clients early in the pilot study period to react negatively to the donation policy subsided during the six-months over which the study was carried out.

Midwives' Roles

Providers reported that the introduction of the donation policy was cumbersome and uncomfortable. Early on, they had difficulty communicating the policy to clients. Although compliant with policy procedures, providers said that they would prefer not to be responsible for asking for and collecting donations. However, because of the need for national program sustainability, nearly all providers agreed that if clients must be asked to make donations, the midwife was the best person to do it and that it should be done in the family planning encounter room. Discomfort among midwives appears to have decreased as the pilot study progressed, perhaps in part because midwives were often given control over the use of family planning donation revenue retained at the PHC facility (20 percent of revenue collected).

According to donation policy procedures, in all PHC facilities midwives established the payment status for each family planning client. However, staff at each facility were given the option to decide whether the midwife would also collect donations and issue receipts, or refer clients to an administrative clerk. Most facilities eventually assigned this task to the midwife and providers said that this worked well. When asked if all facilities should be required to follow the same donation collection procedure, most providers agreed that each facility should have the flexibility to tailor this procedure to suit individual facilities.

Record Keeping

Focus-group discussions revealed that providers preferred to record each client's payment category (full, partial, or exempt) in the "comments" column of the family planning clinic record book (using an alias to ensure confidentiality), rather than the CTF. PHC facility staff supported continuation of this new procedure. Other than this, staff at PHC facilities did not report any difficulty with data recording procedures. Processing CTFs was reported the most burdensome of pilot study procedures; nevertheless, PHC facility staff complied well with this requirement. The CTF was used specifically for collecting information for evaluation of the pilot study. Since it will not be required during the expansion phase of the donation policy, data collection procedures should pose no serious problems. The only exception is the procedure for marking clients' payment status on the facilities' patient registry log. This will require an administrative decision before implementation during the expansion phase.

Donation Fees

During focus-group discussions and interviews with providers, most discussions revolved around the three-tiered donation levels. Providers clearly understood the need for the donation policy to sustain their ability to provide family planning services. In this light, they were generally supportive of the donation levels because they felt they provided flexibility and discretion in distinguishing among clients most able to pay, those able to pay something, and those for whom any donation would constitute a hardship. However, they expressed some discomfort about appearing to leave clients with "an impression of haggling." Still other providers said they would prefer a compulsory fee system with no exemption option, or a donation policy in which establishing clients' payment status was done somewhere other than at the PHC facility, perhaps through means testing. These alternatives are not feasible given the existing legal and policy framework in Turkey. Furthermore, providers generally agreed that the three-tier donation system is more plausible. Most providers felt that the donation levels in their region were appropriate.

Revenue Retention

PHC facilities retained 20 percent of donations collected from family planning clients, with the remainder forwarded to the provincial HSAF branch, compared with about a 50 percent retention rate for client donations for other health services. Facility staff considered the share of donation revenue collected from family planning clients to be low but expressed acceptance of this in recognition of the importance of national family planning program sustainability.

Transfer of Funds

No problems were identified with the transfer of donation revenue from PHC facilities to provincial HSAF branches or Provincial Health Directorates. That the flow of money and forms was tied to the exchange of HSAF receipt books was instrumental in ensuring that this process

worked effectively. However, final agreement on donation policy issues was not reached between HSAF headquarters and the MOH during the pilot study period, thus preventing the transfer of donation revenues and forms from provincial HSAF branches to HSAF headquarters. It has been determined that provincial HSAF branch staff have deposited the appropriate amount of donation revenue, as defined in the retention aspects of the policy, in local bank accounts, awaiting orders to transfer these funds to HSAF headquarters.

In summary, the belief that, in principle, family planning services should be provided free-of-charge to all who seek them still prevailed among facility staff and provincial health leaders. However, nearly all recognized that the sustainability of the national family planning program is dependent on implementation of the donation policy, and in that regard were supportive. In light of national program sustainability concerns, it was generally agreed that implementation of the donation policy should be expanded to other provinces. Well-designed orientation and training sessions, especially for family planning midwives, was seen as important to expansion. Providers also expressed concern that the proportion of clients exempted would increase over time.²³

IV. Recommendations

The donation policy is intended to serve as the MOH's principal mechanism to target subsidized contraceptive commodities to people most in need of those subsidies, that is, the poor. This targeting strategy is an integral component of the MOH's national family planning program self-reliance strategy, designed to ensure the sustainability of the national family planning program, and in particular, the public sector's role in service delivery. By choosing to implement this targeting strategy, the MOH has implicitly accepted that certain inevitable tradeoffs are unavoidable.

The MOH wishes to preserve its long-standing policy of providing family planning services to all that seek them. However, budgetary realities prevent it from procuring all the contraceptive commodities required to provide contraceptives to all who have been seeking them when offered free-of-charge. However, seeking donations from better-off family planning clients, even when donation fees are lower than those in the private sector and when clients may without question opt out of paying a donation, may encourage some clients to stop using public sector sources. Such behavior was indeed observed in the pilot study. The public sector program will no doubt change over time, focusing more on the less well off, compared to the current program. Although the voluntary nature of the donation policy, as designed, will allow MOH facilities to provide family planning supplies to everyone who seeks them, it is likely to have the effect of encouraging some clients to cease patronizing the ministry's services.

²³ The reason for this belief was not explored, although one might expect this to occur if better-off clients opt to switch their source for contraceptive supplies to a private sector outlet. The remaining public sector clientele would be increasingly composed of the poor and the near poor, a higher proportion of which can be expected to exempt themselves from making a donation. Were this to occur, the volume of contraceptive commodities required to sustain the public sector's family planning services might also decrease (barring new modern method users entering the system), relieving pressure on the need to raise resources above those allocated to MOH in their annual budget.

Recommendations drawn from the pilot study are presented here in three broad categories: (1) donation levels, (2) administrative procedures, and (3) expansion.

A. Donation Price and Retention Levels

A1: Three-tiered donation levels should be implemented in the expansion provinces. Most providers in the pilot study areas expressed support for the three-tier donation levels, recognizing the value in giving providers the flexibility to examine the differences among clients in their willingness-to-pay donations. In addition, the higher proportion of clients who opted for a partial donation payment in the high donation area testifies to the importance of maintaining a partial payment option at higher prices (see recommendation A2).

A2: Donation levels should be set at or above the levels set in the high donation area. The full donation price should be calculated to allow for recovery of the expected full U.S.dollar cost of the commodities and the full facility and branch retention allowances. Setting donation levels at less than this amount will likely result in insufficient revenue collected to close the MOH's contraceptive financing gap. Because of the recent and expected devaluation in the TL, donation prices may need to be set above those tested in the high donation area in order to ensure that sufficient revenue is raised. There may be some concern about clients' willingness to pay higher TL donations than those tested in the pilot study, but the partial payment and exemption categories of the donation policy should protect those who cannot or will not pay higher prices. The impact of donation prices, at whatever level they are set, should be monitored regularly.

A3: The donation levels should list the price for a one-month supply of OCs, eliminating a separate price for a two-month supply. During the pilot study, pricing two cycles at double the price of one cycle worked well. Therefore, there is no need to list a two-month supply separately. Donation policy guidelines should instruct providers that if clients request a two-month supply, they should be asked to pay twice the amount listed for a one-month supply. Clients who are unable to pay the full donation price for a two-month supply should be encouraged to accept a one-month supply and pay what they can, unless there are extenuating circumstances justifying their need for a two-month supply.

A4: Price levels set for the initial expansion period should remain in effect until the end of December 2002. Some expansion provinces will not be oriented until early 2002, and it is recommended that all provinces remain stable at their initial donation levels for the duration of that calendar year. This will provide clients and providers with sufficient time to adjust to the new policy. This will also require that donation levels be set to accommodate expected prices that HSAF will have to pay for central procurement through late 2002 (see A2). Need for donation price changes should be assessed annually thereafter to adjust for changes in the exchange rate between TL and the U.S. dollar, as well as changes in wholesale prices for contraceptives.

A5: Retention rates for donation revenue collected should be set at 20 percent for facilities where they are collected, and 10 percent of the remaining amount transferred from facilities should be retained by provincial HSAF branches. During the pilot study, these retention rates were well accepted and provided HSAF headquarters with 72 percent of revenue collected at the PHC facility level for central procurement of contraceptive commodities.

B. Administrative Procedures

B1: In all facilities in expansion provinces, family planning clinic midwives should be designated to discuss the donation policy with clients, and, in consultation with clients, help them determine their payment category (full payment, partial payment, or exempt).

B2: The decision about who in the facility should collect donations from clients and issue receipts should be left to the discretion of each individual facility. During orientation sessions, providers and clinic staff should be made aware that in pilot study facilities, it worked best when family planning clinic midwives performed these functions. However, a procedure whereby the midwife issues a payment slip to be taken by the client to the facility administrative clerk, who will collect donations and issue receipts, is also acceptable. Midwives should also be made aware that they may experience some discomfort initially when carrying out these functions, but that most midwives in the pilot study areas reported this to decrease as they and clients became familiar with the policy.

B3: In order to facilitate monitoring and evaluation of the policy, facilities should be required to log donation categories and the method dispensed in the facility's patient registry log. This procedure should be described in the donation policy guidelines and explicitly endorsed by Provincial Health Directors.

B4: In expansion provinces, HSAF branches should be instructed by HSAF headquarters to establish a clear and transparent accounting mechanism to track the transfer of donation revenue funds from facilities to HSAF headquarters. FRFs and BRFs developed and used during the pilot study should be used in this mechanism.

C. Expansion

C1: The donation policy should ultimately expand nationwide to include as many provinces as quickly as practically and politically feasible. The 25 eastern provinces, designated by the government to compose a special development zone, will be excluded in the foreseeable future. This exclusion amounts to a tacit geographic targeting strategy. During the first expansion year, the donation policy should be extended to the 16 most populous provinces, including the three provinces (Adana, Icel, and Izmir) where the pilot study was conducted. According to the analysis of revenue-raising potential (see Section III), expansion to these provinces is likely to fall short of needed funds to close the MOH budget gap for contraceptive procurement. Therefore, further expansion should continue to additional provinces during Year Two.

C2: The donation policy should be expanded to include all districts in the two pilot study intervention areas and the control area. During the pilot study, the policy was implemented in selected districts in Adana and Icel provinces only. The policy was not implemented in any districts in Izmir province, the control area. This will require new orientation sessions in each of these provinces. Additionally, given that a uniform donation price structure will be implemented, administrative and provider staff in pilot study provinces will need reorientation to inform them of the new structure.

C3: All public hospitals in expansion provinces should be instructed to implement the same donation levels as those implemented in PHC facilities. Although there was no strong evidence from the pilot study to suggest that a large-scale shift by clients from PHC facilities to hospitals occurred as a result of the donation policy, the possibility exists that such a shift could take place as clients learn of price differentials. This shift would most likely advantage urban clients who live closer to public hospitals, decreasing the rural–urban equity of the donation policy. Since the principal purpose of including public hospitals in the donation policy is to prevent a shift from PHC facilities and thereby preserve the policy’s revenue-raising potential, it is not recommended that PHC facilities be required to transfer any of the collected donation revenue for contraceptive commodities. The volume of services provided at public hospitals is in any case low compared to PHC facilities, and, their revenue-raising potential is low.

C4: Rural health houses should be excluded from the donation policy. No health houses implemented the donation policy during the pilot study. These PHC facilities were excluded by design. This did not result in any change in the volume of family planning services provided at these facilities, which make up less than one percent of public sector contraceptives dispensed. It is unlikely that clients at other PHC facilities or public hospitals will switch their source of contraceptive supplies to rural health houses in order to avoid the donation policy, as these facilities are located in remote areas and are not easily accessible for clients living in nonremote areas.

C5: The donation policy should be implemented uniformly in all other rural and urban facilities. There was no evidence during the pilot study that the donation policy had a differential, deleterious effect on rural consumers.

C6: All PHC facilities in expansion provinces should be required to implement the donation policy. Two types of situations arose during the pilot study in which participation and compliance was an issue. First, many MCH/FP centers do not participate in the HSAF system, operating instead as independent associations to raise revenue from client donations. These facilities retain 100 percent of such revenue raised, and special effort is required to encourage them to participate in the donation policy. Their participation is important because they obtain their contraceptive supplies from the MOH, and because their service load constitutes an important proportion of MOH contraceptive supplies distributed nationwide. Appeals to national program sustainability were effective in soliciting their participation in the intervention areas. Appealing to equity concerns (MCH/FP clients are generally better off than clients at other public clinics) was also effective.

The second situation involved facilities where staff attended the orientation session preceding policy implementation but did not implement the policy. In the pilot study, such cases were limited to smaller, remotely located health centers that were allowed to opt out of the study. During national expansion, criteria for participation in the donation policy should be clearly defined and exceptions not allowed. This will result in equity in implementation and enforcement of the policy and will prevent other facilities from dropping out.

C7: Emphasize the maturation effect during orientation sessions in expansion provinces to familiarize providers and administrators with expected learning processes and their impact, as observed in the pilot study, on client as well as provider attitudes and behavior.

C8: Monitor staff response in PHC facilities, especially during the first quarter after implementation in each new province. A provider-learning phase was documented during the pilot study period. Providers' comfort with their role in implementing the donation policy improved over time; however, monitoring for trouble spots and support by the pilot study coordinators may have played an important role in the maturation process. It will be important to devise similar mechanisms to identify problem areas and to intervene in each province as the expansion proceeds.

C9: Midwives from the pilot study areas should be recruited to participate in the expansion phase orientation sessions. These midwives should be selected on the basis of their success in implementing the policy at their PHC facility, their articulateness, and their potential as trainers.

Annex 1: Client Tracking Form

Name of the Health Facility: _____

Form No: _____

Service Date <small>(Day, Month, Year)</small>	Client Information			Method and Amount of Donation Paid <small>(Check mark the relevant cell for each client)</small>									
	Name	Age	Address	IUDs			Condoms			Oral Contraceptives			Quantity*
				Full	Part	None	Full	Part	None	Full	Part	None	
			TOTAL										

* For oral contraceptives only, record the number of cycles dispensed.

Annex 2: Facility Reporting Form

Facility: _____ Period: _____

	Number of Users			
	Full Payers	Partial Payers	Non Payers	T O T A L
IUDs				
Condoms				
Oral contraceptives				
T O T A L				

A – Total Contraceptive Donation Revenue: _____ **TL**

B – Retention by the Facility (A x 0.2): _____ **TL**

C – Amount due to Branch (PHD) (A - B): _____ **TL**

Prepared by

Name:

Title:

Signature:

Date:

Approved by

Name:

Title:

Signature:

Date:

Annex 3: Branch Reporting Form

Facility: _____ Period: _____

	Number of Users			
	Full Payers	Partial Payers	Non Payers	T O T A L
IUDs				
Condoms				
Oral contraceptives				
T O T A L				

A – Total amount transferred by facilities: _____ **TL**

B – Retention by the Branch (A x 0.1): _____ **TL**

C – Amount due to Foundation HQ (A - B): _____ **TL**

Prepared by

Name:

Title:

Signature:

Date:

Approved by

Name:

Title:

Signature:

Date:

Annex 4: Tables

Table 1: Distribution of donations by area

Area	Full Payment		Partial Payment		Exempt		TOTAL	
	N	%	N	%	N	%	N	%
High	6,259	44	2,514	18	5,372	38	14,145	100
Medium	3,501	53	391	6	2,712	41	6,604	100
Low	17,261	53	2,026	6	13,278	41	32,565	100
TOTAL	27,021	51	4,931	9	21,362	40	53,314	100

$X^2=1,691.43$ df=4 p≤0.001

(Note: There is no difference between medium and low donation payment rates – $X^2=0.92$; df=2; p≤1)

Table 2: Distribution of payment status by method

Method	Full		Partial		Exempt		TOTAL	
	N	%	N	%	N	%	N	%
IUDs	4,479	55	1,509	18	2,198	27	8,186	100
OCs	8,047	47	1,981	12	6,977	41	17,005	100
Condoms	14,495	52	1,441	5	12,187	43	28,123	100
TOTAL	27,021	51	4,931	9	21,362	40	53,314	100

$X^2=1,874.01$ df=4 p≤0.001

Table 3a: Distribution of donations by type of service site

Facility	Full		Partial		Exempt		TOTAL	
	N	%	N	%	N	%	N	%
MCH/FP	3,811	67	526	9	1,395	24	5,732	100
Health Center	23,210	49	4,405	9	19,967	42	47,582	100
TOTAL	27,021	51	4,931	9	21,362	40	53,314	100

$X^2=713.20$ df=2 p≤0.001

Table 3b: Distribution of donations by type of service site (method breakdown)

Facility	Method	Full		Partial		Exempt		TOTAL	
		N	%	N	%	N	%	N	%
MCH/FP^a	IUDs	1,479	69	337	16	333	15	2,149	100
	OCs	751	64	107	9	315	27	1,173	100
	Condoms	1,581	66	82	3	747	31	2,410	100
	Total	3,811	67	526	9	1,395	24	5,732	100
Health Center^b	IUDs	2,999	50	1,172	19	1,865	31	6,036	100
	OCs	7,296	46	1,874	12	6,662	42	15,832	100
	Condoms	12,915	50	1,359	5	11,440	45	25,714	100
	Total	23,210	49	4,405	9	19,967	42	47,582	100
TOTAL		27,021	51	4,931	9	21,362	40	53,314	100

^a $X^2=305.77$ $df=4$ $p \leq 0.001$

^b $X^2=1,475.92$ $df=2$ $p \leq 0.001$

Table 4a: Proportions of payment in urban and rural health care sites

Facility	Full		Partial		Exempt		TOTAL	
	N	%	N	%	N	%	N	%
Urban	24,001	51	4,305	9	19,178	40	47,484	100
Rural	3,020	52	626	11	2,184	37	5,830	100
TOTAL	27,021	51	4,931	9	21,362	40	53,314	100

$X^2=28.40$ $df=2$ $p \leq 0.001$

Table 4b: Proportions of payment in urban and rural health care sites (method breakdown)

Facility	Method	Full		Partial		Exempt		TOTAL	
		N	%	N	%	N	%	N	%
Urban^a	IUDs	4,129	55	1,350	18	2,051	27	7,530	100
	OCs	6,910	46	1,742	12	6,294	42	14,946	100
	Condoms	12,962	52	1,213	5	10,833	43	25,008	100
	Total	24,001	51	4,305	9	19,178	40	47,484	100
Rural^b	IUDs	350	53	159	24	147	22	656	100
	OCs	1,137	55	239	12	683	33	2,059	100
	Condoms	1,533	49	228	7	1,354	43	3,115	100
	Total	3,020	52	626	11	2,184	37	5,830	100
TOTAL		27,021	51	4,931	9	21,362	40	53,314	100

^a $X^2=1,730.17$ $df=4$ $p\leq 0.001$

^b $X^2=235.46$ $df=4$ $p\leq 0.001$